New Jersey Department of Health and Senior Services

CREUTZFELDT-JACOB DISEASE REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race

☐ White ☐ American Indian ☐ Unknown/Other
☐ Black ☐ Asian

Ethnicity

☐ Hispanic ☐ Unknown
☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Possible ☐ Probable ☐ Confirmed

Clinical:

Confusion and/or forgetfulness? ☐ Yes ☐ No ☐ Unknown
Cortical dementia? ☐ Yes ☐ No ☐ Unknown
Ataxia? ☐ Yes ☐ No ☐ Unknown

Risk Factors:

Did patient have a history of corneal transplant? ☐ Yes ☐ No ☐ Unknown
If Yes, date of corneal transplant: ____ / ____ / ____
Did patient live more than 6 months in England in last 10 years? ☐ Yes ☐ No ☐ Unknown
If yes, when: _____
Did patient have familial history of dementia? ☐ Yes ☐ No ☐ Unknown
If yes, please specify: _____

Laboratory Tests:

CSF examination date: ____ / ____ / ____
Protein: _____ WBC/mL: _____
Was CSF tested for presence of protein 14-3-3? ☐ Yes ☐ No
If yes, protein 14-3-3 present? ☐ Yes ☐ No
Was EEG examination performed: ☐ Yes ☐ No
If yes, does it show periodic or pseudoperiodic paroxysms of triphasic or sharp waves (0.5 to 2.0 Hz) against a slow background? ☐ Yes ☐ No
If no, specify what was observed: _____
Was diagnosis confirmed by histopathological examination (brain biopsy or post-mortem examination)? ☐ Yes ☐ No
If yes, specify results: _____

Comments:

Name and Title of Person Submitting Report	Telephone Number